

## THERAPIST SATISFACTION WITH FOUR MANUAL-BASED TREATMENTS ON A NATIONAL MULTISITE TRIAL: AN EXPLORATORY STUDY

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The National Institute on Drug Abuse (NIDA) Collaborative Cocaine Treatment Study was a NIDA-funded cooperative agreement involving four clinical sites, a coordinating center, and NIDA staff. The coordinating center at the University of Pennsylvania included Paul Crits-Christoph, PhD (principal investigator), Lynne Siqueland, PhD (project coordinator), Karla Moras, PhD (assessment unit director), Jesse Chittams, MA (director of data management/analysis), and Larry R. Muenz, PhD (statistician). The collaborating scientists at the Treatment Research Branch, Division of Clinical and Research Services at NIDA, were Jack Blaine, MD, and

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Lisa Simon Onken, PhD. The four participating clinical sites were University of Pennsylvania: Lester Luborsky, PhD (principal investigator), Jacques P. Barber, PhD (co-principal investigator), Delinda Mercer, MA (project director); Brookside Hospital: Arlene Frank, PhD (principal investigator), Stephen F. Butler (co-principal investigator), Sarah Bishop, MA (project director); Harvard Medical School, McLean Hospital, and Massachusetts General Hospital: Roger D. Weiss, MD (principal investigator), David R. Gastfriend, MD (co-principal investigator), Lisa M. Najavits, PhD (project director), and Margaret Griffin (research associate); and University of Pittsburgh, Western Psychiatric Institute and Clinic: Michael Thase, MD (principal investigator), Dennis Daley, MSW (co-principal investigator), Ishan M. Salloum, MD (co-principal investigator), and Judy Lis, MSN (project director). The training unit heads of the Cognitive Therapy Training Unit were Aaron T. Beck, MD (University of Pennsylvania), and Bruce S. Liese, PhD (University of Kansas Medical Center); heads of the Supportive-Expressive Therapy Training Unit were Lester Luborsky and David Mark, PhD (University of Pennsylvania); heads of the Individual Drug Counseling Unit were George Woody, MD (Veterans Administration, University of Pennsylvania Medical School), and Delinda Mercer, MA (University of Pennsylvania); and heads of the Group Drug

*Ratings by 44 therapists in 4 modalities (cognitive, supportive–expressive, individual drug counseling, and group drug counseling) were obtained during one of the largest outcome trials ever conducted, the National Collaborative Cocaine Treatment Study. Views of the treatments, desired changes, and influences on implementation were studied. Therapists were highly positive about the treatments. However, their likelihood of using them in the future without modification was low, and they viewed them as too short. Supervision was perceived as more important than manuals and taping of sessions as more important than adherence scales. It took therapists an average of 8 months to feel comfortable with the treatments. New learning was therapists’ primary motivation, more than extrinsic factors such as pay. Supportive–expressive therapists reported the most negative views, among modalities.*

Treatment manuals are one of the major innovations in psychotherapy of the past several decades. The proliferation of manuals, their now ubiquitous use in treatment outcome studies, and their widespread application across many theo-

retical orientations make them a powerful presence in the intervention field.

Yet only a few studies have empirically addressed therapists’ satisfaction with manuals. Najavits, Weiss, Shaw, and Dierberger (2000) surveyed 47 cognitive–behavioral therapists and found their opinion of manuals highly positive. The therapists also reported extensive use of manuals, had few concerns, and expressed preferences of what should be included in the “ideal manual” (e.g., patient handouts and a description of frequently encountered clinical problems). Addis and Krasnow (2000) surveyed 891 practicing psychologists and found variability in their response to manuals. For example, they endorsed both positive views (“Treatment manuals can help keep therapists on track during therapy”) and negative views (“Treatment manuals ignore the unique contributions of individual therapists”). A majority (53%) reported at least some use of manuals in their clinical work. Finally, Godley, White, Diamond, Passetti, and Titus (2001) used a qualitative interview-based approach with 19 therapists participating in an outcome study for adolescent substance abuse. The authors reported a positive response to the five manuals used on the project, including therapists’ perception that they could address patients’ individual needs within the context of a manual and a sense that the manuals allowed flexibility yet also helped keep them structured and consistent in their clinical work. In addition, both Najavits et al. (2000) and Godley et al. (2001) reported therapists’ view that supervision was a key element in addition to the manual per se. All of these authors called for the need for further study of therapists’ views of manuals, highlighting in particular the need for more diverse sampling across a range of therapists and orientations, and the need to solicit therapists’ views to help refine and inform further treatment manual development. All noted that manuals have generated considerable controversy in the field, reinforcing the classic split between therapy practice and research. The view of manuals as a tool imposed by researchers and third-party payers rather than inherently of value to clinicians is of particular concern.

In the current study we sought to elicit the opinions of therapists in the context of one of the largest psychotherapy trials ever conducted, the Collaborative Cocaine Treatment Study (NCCTS; Crits-Christoph et al., 1999). This five-

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site study of 487 patients was designed to evaluate four different manuals for the treatment of cocaine dependence: cognitive (CT), supportive-expressive (SE; a variant of psychodynamic), 12-step individual drug counseling (IDC), and 12-step group drug counseling (GDC). It provided a unique opportunity to explore three central topics: (a) therapists' views of the treatment manual (e.g., how satisfied they felt with the manual; how long it took to feel comfortable with it); (b) desired modifications to the treatment (e.g., fewer or more sessions); and (c) influences on their use of the treatment (both internal, such as the pay provided on the study, and external, such as their own personal therapy). In particular, we were interested in how likely therapists would be to use the treatment once they were no longer required to do so as part of the outcome trial: Was the treatment truly a resource that would influence their future clinical work or more of a task to be done just while being heavily monitored? These three areas are believed to have significant implications for future training, both as part of research studies and in front-line settings where therapists' own preferences guide adoption of treatment models.

The NCCTS was exceptionally rigorous in its attention to therapist selection and training, thus providing insight on how therapists view a treatment when it is implemented at the highest possible level. For example, there was a 4-year pilot phase before the main outcome trial was begun, during which major study design decisions were made, research and clinical protocols were developed (including the four treatment manuals), and therapists were intensively trained. During this pilot phase, 286 patients were treated, and therapists received weekly individual supervision based on the review of full audiotaped sessions for at least four training cases (a minimum of 32 tapes per therapist); they received 8 full days of training workshops conducted by the treatment manual developers; and they were required to demonstrate mastery of their treatment through an adherence-based certification process. Patient selection, assessment, and other procedures were also extensive and are detailed elsewhere (Crits-Christoph et al., 1997). The study is exploratory, however, in that it used a newly developed measure to survey therapists' views, the measure was administered at only one point in time, the number of therapists per modality varied, the patient sample was restricted to cocaine dependence, and

only therapists' views were obtained (we did not address patient outcomes or satisfaction).

Throughout the current study, the broader term *protocol treatment* is used, rather than *treatment manual*, to more accurately convey that therapists are responding to a manual-based treatment protocol, not just to the manual itself. The protocol includes, for example, the number and pacing of sessions and the purity of treatment enforced.

The current study draws from a self-report questionnaire administered to all therapists who achieved certification in their modality. Capturing clinicians' views of their treatment may help inform future efforts to implement manual-based therapies.

## Method

### *Participants*

Therapists ( $n = 44$ ) were administered the Protocol Implementation Questionnaire (PIQ) at a single time point, just after the completion of the 4-year pilot phase of the study but prior to the start of the main outcome trial. All therapists who achieved certification in their orientation were asked to participate. This time point was selected to obtain therapists' views of their protocol treatment after they successfully completed the intensive therapist training that was a key focus of the pilot phase (see below). By this time point, 3 years of therapist training had occurred, and each therapist had treated at least four cases under close supervision. It was believed that their views on PIQ questions such as views of the manual, supervision, adherence ratings, and degree of time needed to learn the treatments would be most accurate if collected when these experiences were still fresh in memory yet after the therapists had been certified to competence in their modality (ensuring a sample that had indeed mastered the treatments). Some therapists who achieved certification in their orientation did not turn in the completed measure; thus, the sample size of 44 is slightly lower than the total number of therapists in the main outcome trial ( $n = 50$ ). Prior reports describe the rationale and methods of the study (Crits-Christoph et al., 1997), the main outcome results (Crits-Christoph et al., 1999, 2001), and the impact of training on therapist performance (Crits-Christoph et al., 1998). Detailed description of the therapist selection, training, and

certification procedures can be found in the last article.

Of the 44 therapists in this analysis, 10 were IDC, 14 were CT, 13 were SE, and 7 were GDC. Their mean age was 40.66 ( $SD = 6.98$ ). Most were Caucasian ( $n = 39, 88.6\%$ ), with 3 African American (6.8%), 1 Asian (2.3%), and 1 "other" (2.3%). Most were male ( $n = 27, 61.4\%$ ). Most were doctoral psychologists ( $n = 20, 45.5\%$ ), followed by master's level clinicians ( $n = 13, 29.5\%$ ), bachelor's level clinicians and certified alcohol and drug counselors ( $n = 8, 18.2\%$ ), nurses ( $n = 2, 4.5\%$ ), and 1 psychiatrist (2.3%).

Therapists were selected by supervisors for each therapy orientation on the basis of a combination of background education and training, reference letters, and two audiotaped samples of their therapy sessions that were rated for quality. Supervisors were selected by the heads of the training units on the basis of their expertise within psychodynamic, cognitive therapy or drug counseling orientations, and most were coauthors of the treatment manuals for the study. There were three SE supervisors, four CT supervisors, and four IDC supervisors. Each supervisor rated the therapist for adherence as part of the clinical supervision on the basis of audiotapes of full sessions, with a tape sampling schedule that was consistent across orientations. The average patient had 5.3 ( $SD = 1.7$ ) sessions rated by the supervisor (Crits-Christoph et al., 1998). Only therapists who achieved satisfactory adherence were certified to continue into the main outcome trial.

Therapists were trained over a 3-year period through a combination of in-person training workshops and telephone supervision. Therapists attended four 2-day training workshops that consisted of didactic material, role plays, and discussion of case examples. The training unit directors, all supervisors, and all therapists attended the workshops. The first workshop was primarily didactic and focused on the theoretical foundation of the treatment. The second workshop, and especially the third and fourth workshops, emphasized a review of techniques and case formulations using patients with cocaine dependence who were in treatment with the study therapists. Videotapes and audiotapes were used to illustrate clinical issues.

Each therapist was assigned four training cases (of at least 1-month duration), usually one at a time, during the training phase. All sessions were

audiotaped and mailed to the supervisor within 2–3 days, and at least eight full sessions per case were rated for adherence. Supervision focused on feedback based on the supervisor's adherence ratings. See Crits-Christoph et al. (1998) for a listing of adherence scales used.

### Treatments

The three individual treatments studied were *supportive-expressive therapy* (Mark & Luborsky, 1992), a psychodynamic treatment derived from Luborsky (1984); *cognitive therapy* (Beck, Wright, Newman, & Liese, 1993); and *individual drug counseling* (Mercer & Woody, 1992), based on the 12-step addiction model. All patients received *group drug counseling* in addition to their individual therapy (Mercer, Carpenter, Daley, Patterson, & Volpicelli, 1994), based on the 12-step addiction model. During the pilot phase of the study, patients were randomized to one of the three individual treatments following a brief stabilization phase in which they had to achieve initial abstinence (defined as having three consecutive drug-free urinalysis screens).

The treatment was 6 months long and consisted of twice-weekly sessions for the first 3 months of treatment and once-weekly sessions for Months 4 through 6. In addition, three monthly booster sessions were offered to patients after this 6-month period. The 286 pilot study patients attended an average of 17.9 sessions ( $SD = 11.0$ ). Thirteen percent of patients met our criteria for dropout (defined as having no face-to-face contact with therapist for 8 weeks) by 1 month, 29% by 3 months, and 47% by 6 months.

The goal of the training phase was for each individual therapist to treat four patients for at least 1 month. If a supervisor determined that a therapist needed more practice, additional training cases were assigned. Participation in this project was demanding of therapists, both in amount of time and in the expectation that they would learn the treatment sufficiently to be certified competent to continue into the main outcome trial.

### Patients

The inclusion criteria for the study were a primary diagnosis of current cocaine dependence, cocaine use in the prior 30 days, ages 18–60, and a stable mailing address with plans to reside in the area for the next 2 years. Exclusion criteria

were primary diagnosis of current polysubstance dependence or alcohol dependence (patients could have other current substance-dependence diagnoses as long as the cocaine dependence was primary), current opioid dependence, bipolar or psychotic disorder, and dementia or organic brain disorder. Other exclusion criteria included imminent suicidal or homicidal risk, need for or unwillingness to discontinue current psychotropic medications, serious illness that would prevent treatment attendance, impending incarceration, being mandated to treatment, or residence in a halfway house.

Patient characteristics for the main outcome trial are described in detail in Crits-Christoph et al. (1999). Most relevant to the current analysis is the description of patients from the article that summarized therapist training (Crits-Christoph et al., 1998). As reported in that article, the sample comprised 202 patients who were randomized to treatment and had a minimum number of adherence scores (see below). At baseline, the mean age was 33.3 years ( $SD = 6.7$ ), and 69% were male. Fifty-seven percent were Caucasian and 43% minority, primarily African American (with 3% Hispanic or Native American). Sixty-two percent were employed. Seventy-five percent of the patients lived alone, and 25% were married or lived with a partner. Seventy-three percent were primarily crack smokers, 23% were primarily intranasal users, and 4% primarily injected cocaine. On average at baseline, patients used cocaine a mean of 8.9 days per month ( $SD = 7.8$ ) and had been using cocaine an average of 6.2 years ( $SD = 4.5$ ). Fifty-two percent had other current substance dependence diagnoses, with 37% meeting criteria for alcohol dependence and 11% for cannabis dependence as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.; American Psychiatric Association, 1987). In addition, 28% had at least one current Axis I disorder other than substance dependence, including 15% with a depressive disorder (10% major depression). Forty-four percent met criteria for a personality disorder diagnosis on the basis of the Structured Clinical Interview for *DSM-III-R* Axis II (SCID-II; Williams et al., 1992), with the most common being antisocial personality disorder (14%).

### Measures

The PIQ (Najavits, 1996) is a 36-item scale that elicits therapists' views on implementing a

protocol treatment in a research study. The scale has three sections. The first section has 13 general questions, rated 0%–100%. An example of an item is "Overall, how would you rate your current satisfaction with the protocol treatment?" (0% = *not at all satisfied*, 100% = *extremely satisfied*). The second section has 6 multiple-choice questions that ask therapists to identify how they would modify the protocol treatment if they could. For example:

*Number of sessions.* I would make the treatment (check one):

- (a) The same as on the study (39 sessions)
- (b) Longer (how many sessions? \_\_\_\_\_)
- (c) Shorter (how many sessions? \_\_\_\_\_)
- (d) Other (please describe: \_\_\_\_\_)

The third section has 18 items that explore potential influences on therapists' implementation of the protocol treatment, both within and outside the study, such as "supervision on the study" and "my personal therapy." Each item is rated  $-3$  (*strong negative influence*, i.e., "hindered me from implementing the protocol") to  $3$  (*strong positive influence*, i.e., "helped me to implement the protocol"). The total scale takes approximately 20 min to complete.

### Data Analysis

Descriptive statistics were conducted for each item on the scale. For Sections 1 and 3, on each item, a comparison of the four treatment conditions was conducted using one-way analyses of variance with post hoc Tukey tests for those that were significant. For Section 2, chi-squares were run for the total sample as well as by treatment condition. We did not use a Bonferroni correction, as Type II error was perceived as a more serious threat than Type I error (i.e., this was an exploratory study using a new measure, with small sample sizes per treatment condition).

Because of the limited range of responses on many items in the PIQ, the distributions of all variables were examined, revealing nonnormal distributions on several items. A total of 11 items were transformed after finding that they violated normality assumptions per the Box-Cox test. Transformed variables are indicated in the tables. Note that the means for the transformed values are reported in the tables untransformed (so as to be meaningful in relation to the original scaling of the item and in relation to other items in the

table); however,  $F$  and  $p$  values and post hoc tests represent the transformed values (for accuracy).

Finally, paired-samples  $t$  tests were conducted for select items of interest, and qualitative responses (“write-in” comments) are also provided.

## Results

Results are described in relation to the three central topics of this article: *general views* on implementing the protocol treatment, *desired modifications* to the protocol treatment, and *influences* on implementing the protocol treatment (both within and outside of the study). Results for each topic are displayed in Tables 1–3, respectively, which provide descriptive statistics for every item as well as comparisons by treatment condition.

### *General Views on Implementing the Protocol Treatment*

Several findings are evident in Table 1. First, therapists were, overall, highly positive about their protocol treatment. The means for the full sample were very high for most items in Table 1 (all scaled 0%–100%); that is, they felt strongly able to conduct their treatment (89%), they were satisfied with their treatment (80%) and felt comfortable implementing it (81%), they felt they could be honest with their supervisors regarding their views of the treatment (93%), they felt the treatment fit the patients they faced on the study (71%), and they reported strong allegiance to the treatment (79%). They also viewed themselves as highly effective therapists in general (84%) and with cocaine-dependent patients in particular (74%), although interestingly, the former was significantly higher than the latter in a paired-samples  $t$  test,  $t(43) = 4.60, p < .01$ , suggesting the relative difficulty of this patient population.

One of the most striking findings is that despite such overall positive views of their treatment, therapists’ likelihood of using the treatments *without modifications* was low (40%). In contrast, their likelihood of using the treatments *with modifications* of their choosing was much higher (70%), a significant difference in a paired-samples  $t$  test,  $t(43) = -5.45, p < .01$ .

Another interesting finding was that SE therapists consistently appeared to be outliers when compared with the other orientations. Of the 13 items indicating significant differences among orientations, 10 showed SE therapists differing

from the others, all in the direction of SE therapists finding the work more difficult: SE therapists felt less able to conduct their treatment than IDCs; they were less satisfied with their treatment than CT therapists; they reported that it took them longer to learn the treatment than did GDCs and IDCs, and that it took more effort than IDCs; they could not be as honest with their supervisors as GDCs; they did not believe their treatment fit patients on the study as much as CT therapists; they felt less comfortable implementing their treatment than did IDCs and CT therapists; and they felt less allegiance toward their treatment than did GDCs. The three remaining findings all represented differences between CT therapists and IDCs, with the former reporting more difficulty: CT therapists found that it took longer to learn the treatment, that it took more effort, and that they would be more influenced by patient characteristics in choosing whether to implement the treatment in the future. In general, the pattern of findings might suggest that the psychotherapy orientations (SE and CT) were perceived as more difficult to learn and implement than the drug counseling orientations (IDC and GDC).

Another notable finding in Table 1, based on the full sample, is that therapists’ likelihood of implementing the protocol treatment would be based largely on clinical considerations (patients’ presentation, similarity to patients on the study, and length of treatment), rather than on social influence (i.e., whether other therapists were using the treatment in their setting).

Finally, it is interesting to note that it took over 8 months for therapists to feel comfortable conducting the treatment and that it took a moderate amount of effort to learn it (59%). These results may help inform training in protocol treatments.

### *Desired Modifications to the Treatments*

If therapists could choose, how would they want to modify their protocol treatment? The only finding for the sample as a whole was a wish for their treatment to be longer (68%). All other significant chi-squares in the table indicated that specific elements of the treatment were perceived as *not* needing any change from how they were conducted on the study: the booster sessions, the purity of treatment, the balance between technique and process, and the absence of vocational counseling. As for differences among treatment conditions, there were virtually none; with only 2

TABLE 1. General Views on Implementing the Protocol Treatment

Question	M (SD)				ANOVA	
	Total sample	CT	IDC	SE	GDC	F <sup>d</sup> p
Overall current <i>ability</i> to conduct the treatment?	89.21 (8.56)	90.00 (5.55)	95.00 (5.77)	82.69 (8.57)	91.43 (10.29)	5.60 .003 <sup>e</sup>
Overall <i>satisfaction</i> with the treatment?	79.84 (15.77)	87.50 (6.72)	83.00 (13.58)	69.46 (22.09)	79.29 (6.73)	3.70 .02 <sup>d</sup>
Approximately how <i>long</i> to feel comfortable implementing the treatment? (weeks) <sup>a</sup>	32.81 (34.88)	35.07 (23.59)	7.60 (4.77)	63.00 (45.46)	12.57 (10.69)	9.64 .000 <sup>e</sup>
How much <i>effort</i> to implement the treatment?	58.86 (26.12)	70.00 (14.41)	32.50 (23.36)	71.54 (20.96)	50.71 (29.50)	8.28 .000 <sup>f</sup>
How <i>frequently</i> will you use the treatment in the future without modifications?	40.00 (30.35)	44.29 (34.63)	43.50 (30.92)	35.00 (30.00)	35.71 (25.07)	0.29 .84
How <i>frequently</i> will you use the treatment in the future with modifications you choose to make?	70.00 (25.72)	78.93 (27.96)	54.00 (30.62)	76.15 (18.16)	63.57 (15.47)	2.48 .08
To what extent will your use of the treatment in the future be <i>influenced</i> by the following:						
Patients' clinical presentation <sup>a</sup>	79.65 (19.89)	89.29 (14.39)	66.11 (25.47)	78.46 (15.19)	80.00 (22.36)	2.93 .05 <sup>g</sup>
Patients' similarity to patients on this study <sup>a</sup>	61.91 (34.14)	65.39 (34.12)	62.78 (35.63)	54.23 (38.67)	68.57 (27.34)	0.34 .80
Patients' length of treatment (i.e., ability to stay in treatment) <sup>a</sup>	68.93 (28.98)	63.46 (28.75)	71.67 (25.50)	71.54 (30.44)	70.71 (35.64)	0.21 .89
Use of the treatment by other clinicians where I work	16.31 (25.06)	13.85 (21.42)	33.33 (35.36)	6.92 (13.16)	16.43 (26.88)	2.22 .10
How <i>honest</i> did you feel you could be with your supervisor regarding your views of the treatment? <sup>b</sup>	92.61 (12.87)	92.50 (12.67)	98.50 (3.38)	84.23 (16.56)	100.0 (0.00)	3.37 .03 <sup>h</sup>
How often did you feel the treatment <i>fit</i> the particular patients/clinical situations you faced on the study?	71.07 (18.13)	82.64 (12.56)	69.00 (19.55)	60.39 (18.31)	70.71 (14.23)	4.23 .01 <sup>i</sup>
How <i>comfortable</i> did you feel implementing the treatment? <sup>b</sup>	80.91 (18.47)	89.29 (7.81)	90.00 (11.79)	63.46 (21.25)	83.57 (15.20)	4.47 .008 <sup>j</sup>
How would you rate <i>your overall effectiveness</i> as a therapist?	84.32 (11.74)	86.43 (4.97)	84.50 (14.62)	78.46 (14.20)	90.71 (8.86)	2.06 .12
How would you rate <i>your effectiveness as a therapist with cocaine dependent patients?</i> <sup>c</sup>	74.39 (20.07)	75.36 (16.23)	79.80 (23.88)	61.54 (19.51)	88.57 (7.48)	3.48 .03 <sup>k</sup>
Overall, how much <i>allegiance</i> do you feel toward the treatment?	79.39 (18.29)	83.93 (17.12)	83.50 (15.10)	67.69 (21.08)	86.14 (10.29)	2.88 .05 <sup>l</sup>

Note. For most items, the sample size was 44; however, because of missing responses, *ns* ranged from 38 to 44. All items were rated from 0% to 100%. All items were worded such that 100% referred to "extremely" followed by the key word in the question (the first item was "extremely able," the second item was "extremely satisfied," etc.), unless otherwise indicated. Post hoc comparisons (Tukey honestly significant difference [HSD] tests) were made for significant *F* tests; only Tukey HSD comparisons significant at .05 or lower are listed. Key words are indicated by italics. ANOVA = analysis of variance; CT = cognitive therapists; IDC = individual drug counselors; SE = supportive-expressive (psychodynamic) therapists; GDC = group drug counselors.

<sup>a</sup>Square root transformation was applied to this item. <sup>b</sup>Binary transformation was applied to this item. <sup>c</sup>Binary transformation was applied to this item. <sup>d</sup>CT > SE (*p* < .01). <sup>e</sup>SE > IDC (*p* < .000) and GDC (*p* = .003); and CT > IDC (*p* < .02). <sup>f</sup>IDC < SE (*p* < .000) and CT (*p* = .001). <sup>g</sup>CT > SE (*p* < .03). <sup>h</sup>GDC > SE (*p* < .03). <sup>i</sup>CT > SE (*p* = .006). <sup>j</sup>SE < IDC (*p* = .008) and CT (*p* = .038). <sup>k</sup>GDC > SE (*p* = .022). <sup>l</sup>None significant at .05 or less.

TABLE 2. Desired Modifications to the Protocol Treatment

Modification	Total sample			By treatment condition					
	%	$\chi^2$	<i>p</i>	CT (%)	IDC (%)	SE (%)	GDC (%)	$\chi^2$	<i>p</i>
Number of sessions									
Same as on study	20.5	46.36	.000	21.4	40.0	7.7	14.3	18.38	.03
Longer	68.2			78.6	40.0	84.6	57.1		
Shorter	4.5			0	20.0	0	0		
Other	6.8			0	0	7.7	28.6		
Pacing of sessions									
Same as on study	27.9	6.58	.09	28.6	40.0	16.7	28.6	3.92	.92
Up to clinicians' judgment	39.5			35.7	40.0	50.0	28.6		
Consistent weekly pacing	14.0			14.3	10.0	8.3	28.6		
Other	18.6			21.4	10.0	25.0	14.3		
Booster sessions									
Same as on study	43.2	14.00	.003	28.6	50.0	46.2	57.1	5.82	.76
No booster sessions	9.1			7.1	10.0	7.7	14.3		
More booster sessions	34.1			57.1	20.0	30.8	14.3		
Other	13.6			7.1	20.0	15.4	14.3		
Purity of treatment <sup>a</sup>									
Same as on study	52.3	14.77	.001	64.3	70.0	38.5	28.6	8.89	.18
More eclectic	40.9			21.4	30.0	61.5	57.1		
Other	6.8			14.3	0	0	14.3		
Content of treatment <sup>b</sup>									
Add in family sessions	56.8	0.82	.37	42.9	50.0	61.5	85.7	3.80	.28
Add emphasis on dual diagnosis	36.4	3.27	.07	28.6	50.0	30.8	42.9	1.47	.69
Add in vocational counseling	13.6	23.27	.000	35.7	0	0	14.3	9.43	.02
Other	6.8	32.82	.000	14.3	0	7.7	0	2.49	.48
Emphasis on techniques versus process <sup>b</sup>									
Same as on study	72.7	9.09	.003	85.7	70.0	69.2	57.1	2.17	.54
More emphasis on techniques	4.5	36.36	.000	0	10.0	7.7	0	1.98	.58
More emphasis on process	15.9	20.46	.000	7.1	20.0	7.7	42.9	5.39	.15
Other	6.8	32.82	.000	14.3	0	7.7	0	2.49	.48

Note. CT = cognitive therapists; IDC = individual drug counselors; SE = supportive-expressive (psychodynamic) therapists; GDC = group drug counselors. Therapists checked one response for each item and for "other" could write in their own description of what they would have wanted.

<sup>a</sup>Purity refers to conducting the protocol treatment and *only that* treatment. <sup>b</sup>For this item, therapists could endorse "yes" or "no"; percentage refers to the frequency of "yes" responses. Note that a chi-square was conducted on each response, as therapists could reply "yes" to each.

significant out of 12, we are electing not to interpret the differences, as they may be chance findings. Descriptively, however, it is interesting to note that only IDCs reported any wish for the treatment to be shorter (20%).

#### *Influences on Implementation of the Protocol Treatments*

The four most important influences within the study, as reported by the full sample, were the supervision, being taped, training workshops, and the treatment manual (in that order). All of these elements received a 2 or higher on the scale, which ranged from -3 (*negative influence*) to 3 (*positive influence*). Interestingly, however, the treatment manual was rated lower than supervision according to a paired-samples *t* test,  $t(43) =$

$-3.46, p = .001$ . Also noteworthy was that being rated on an adherence scale had less influence than simply being taped,  $t(43) = 2.70, p = .01$ .

The four lowest influences within the study were, from lowest upward, the threat of job loss, the pay, the patients, and being rated on an adherence scale. Although these were relatively low (ranging from 0.11 to 1.73), none were in the negative range of the scale, indicating that all were considered low to moderate impact, but still positive.

Overall, influences within the study appear to have had more impact than influences outside of the study (compare Sections 1 and 2 of Table 3). Nonetheless, a variety of influences outside of the study had moderate impact on implementation of the protocol treatment (e.g., outside readings, in-

TABLE 3. Influences on Implementation of the Protocol Treatment

Influences	<i>M (SD)</i>					ANOVA <sup>c</sup>	
	Total sample	CT	IDC	SE	GDC	<i>F</i>	<i>p</i>
<b>Influences within the study</b>							
Supervision in the study <sup>a</sup>	2.68 (0.86)	2.93 (0.27)	2.60 (0.70)	2.31 (1.38)	3.00 (0.00)	2.30	.09
Being audiotaped or videotaped	2.21 (1.11)	2.57 (0.85)	2.20 (1.23)	2.00 (0.91)	1.86 (1.68)	0.88	.46
Training workshops in the study <sup>b</sup>	2.12 (0.83)	2.36 (0.75)	2.33 (0.71)	2.00 (0.71)	1.50 (1.23)	3.06	.04 <sup>d</sup>
The treatment manual	2.05 (0.83)	2.07 (0.92)	2.40 (0.52)	1.69 (0.86)	2.14 (0.90)	1.46	.24
Being rated on an adherence scale	1.73 (1.21)	2.50 (0.65)	2.30 (0.68)	0.62 (0.96)	1.43 (1.51)	10.99	.000 <sup>e</sup>
Patients in the study	1.27 (1.37)	1.07 (1.44)	1.80 (1.14)	0.77 (1.48)	1.86 (1.07)	1.68	.19
The pay <sup>c</sup>	0.52 (1.00)	0.57 (0.76)	0.00 (1.33)	0.69 (0.86)	0.86 (1.07)	1.34	.28
The threat of losing my study job if I did not implement it	0.11 (1.21)	0.21 (0.58)	0.20 (1.55)	-0.07 (1.60)	0.14 (0.90)	0.15	.93
<b>Influences outside the study</b>							
Readings outside the study	1.34 (1.08)	1.43 (0.85)	1.50 (1.51)	1.08 (0.95)	1.43 (1.13)	0.36	.78
Informal professional experiences outside the study (e.g., colleagues)	1.25 (0.92)	1.21 (0.80)	1.40 (1.08)	0.77 (0.83)	2.00 (0.58)	3.30	.03 <sup>f</sup>
Formal training outside the study	1.23 (1.10)	1.14 (1.10)	1.90 (1.29)	0.85 (0.80)	1.14 (1.07)	1.94	.14
Life experiences outside the study	1.18 (1.11)	1.00 (0.79)	1.20 (1.03)	0.92 (1.38)	2.00 (1.00)	1.73	.18
Your personal therapy <sup>f</sup>	0.93 (0.95)	0.64 (0.75)	0.50 (0.97)	1.08 (0.64)	1.86 (1.22)	4.00	.01 <sup>g</sup>
Patients outside the study <sup>f</sup>	0.89 (0.87)	1.07 (0.73)	0.70 (1.06)	1.00 (0.71)	0.57 (1.13)	2.29	.09
Supervisors outside the study	0.84 (1.06)	0.71 (0.73)	0.80 (1.23)	0.77 (1.09)	1.29 (1.38)	0.49	.69
<b>Other influences</b>							
Wanting to learn something new	2.40 (0.68)	2.46 (0.66)	2.83 (0.41)	2.15 (0.69)	2.33 (0.82)	1.50	.23
Intrinsic interest in the treatment	2.30 (0.67)	2.36 (0.63)	2.44 (0.53)	2.00 (0.82)	2.57 (0.54)	1.46	.24

*Note.* Post hoc comparisons (all Tukey honestly significant difference [HSD] tests) were made for significant *F* tests; only Tukey HSD comparisons significant at .05 or lower are listed. Items are scaled -3 (*negative influence*) through 3 (*positive influence*), with 0 signifying *no influence*. Rows are sorted in descending order, per section, to convey greatest through least important influences. CT = cognitive therapists; IDC = individual drug counselors; SE = supportive-expressive (psychodynamic) therapists; GDC = group drug counselors; ANOVA = analysis of variance.

<sup>a</sup>Binary transformation was applied to this item. <sup>b</sup>Square root transformation was applied to this item. <sup>c</sup>Shifted log transformation was applied to this item. <sup>d</sup>CT > GDC ( $p = .03$ ). <sup>e</sup>SE < IDC ( $p = .001$ ) and CT ( $p = .000$ ). <sup>f</sup>GDC > SE ( $p < .02$ ). <sup>g</sup>GDC > IDC ( $p = .03$ ).

formal discussion with colleagues, other training, and personal life experiences), which were rated from 1.18 to 1.34.

Two other items were particularly influential: wanting to learn something new (2.40) and intrinsic interest in the treatment (2.30). These means were higher than all other influences except supervision on the study (2.68), suggesting that therapists' innate curiosity may be among the most important factors in their motivation to learn a manualized treatment.

Finally, a few differences emerged among treatment conditions. CT therapists found training workshops more helpful than did GDCs; SE therapists reported less influence of being rated on an adherence scale than CT therapists or IDCs; GDCs reported more impact from informal professional experiences than SE therapists; and GDCs reported their own personal therapy to be more important than did IDCs (where personal therapy simply referred to any psychotherapy the therapists had obtained during their lifetime).

These differences do not appear to represent any overarching pattern. However, they underscore that there can be a myriad of influences on clinicians and that these may differ by profession.

## Discussion

This exploratory study surveyed 44 therapists on their views of manual-based treatments within the context of a large and rigorous psychotherapy outcome trial, the National Collaborative Cocaine Treatment Study. The NCCTS provided a unique opportunity to better understand how therapists felt about four protocol treatments that were diverse in orientation: psychodynamic (i.e., supportive-expressive therapy), cognitive therapy, individual 12-step drug counseling, and group 12-step drug counseling. All of the treatments were implemented with an extremely intensive training procedure conducted over 3 years. All therapists had been selected for high-quality work, both in the initial hiring and through the

certification process for the NCCTS. Only certified therapists completed the PIQ that served as the basis of this article.

Results showed that overall, therapists had very positive views of their protocol treatments (ranging from 71% to 93% on a variety of questions, such as satisfaction with the treatment and level of comfort in implementing it). These data extend previous research by our group (Najavits et al., 2000) and others (Godley et al., 2001) showing that therapists largely report positive reactions to treatment manuals. Such research helps to disconfirm early concerns that therapists would not like manuals, finding them overly prescriptive or rigid, for example. Indeed, it appears that therapists view manuals as a helpful tool that can synthesize clinical information for them. (See Addis & Krasnow, 2000, for a study that obtained more mixed views.)

However, it is very important to note that in this study, therapists reported that their likelihood of using the treatment *without modifications* in the future was low (40%) compared with their likelihood of using the treatment with modifications of their choosing (70%). These findings suggest a bidirectional, fluid process by which therapists are influenced by manuals yet also create modifications of them in the “real” clinical world, compared with the prescriptive world of treatment outcome studies. In this study, therapists abided by strict implementation while on the study but conveyed that once the study was over, they would change the treatment. For treatment developers and outcome researchers, it thus may be important to create a formal process for obtaining therapists’ views on how they would modify the treatment for clinical use once a study ends. Therapists likely have useful insights that could help inform further development of the treatments. In this study, for example, a key recommendation was that the treatments were too short. Although managed care and treatment outcome studies favor short-term treatments, therapists are likely more aware of the realities of how difficult it is to induce genuine change in a difficult population such as cocaine-dependent patients. Indeed, therapists’ significantly higher rating of their effectiveness with patients in general compared with their effectiveness with cocaine-dependent patients underscores this point. However, it is also known that substance abuse patients drop out of treatment at high rates; thus, it is not clear whether providing longer treatment

would be beneficial. For example, 47% of the patient sample in this study had dropped out by 6 months.

Another major finding in this study was that SE therapists consistently had a more difficult time implementing their treatment than did therapists of the other three orientations. Various interpretations are possible: Psychodynamic therapists may simply be less amenable to protocol treatments, especially as theirs is the orientation with the longest history, having existed for most of the 20th century without any manuals. It may also be that the particular version of treatment they conducted (SE) was difficult to utilize with this population. Indeed, both the SE and CT treatments were newly adapted for use with substance abusers as part of the NCCTS, whereas the IDC and GDC conditions were, by definition, always substance abuse treatments and were derived from well-known 12-step models in community settings. The fact that the IDC treatment outperformed both SE and CT in outcome results in the NCCTS perhaps reinforces this point (Crits-Christoph et al., 1999). There was, however, an inherent confound in the NCCTS outcome results in that the two psychotherapy conditions (SE and CT) had therapists with less substance abuse treatment experience than did the two drug counseling conditions (IDC and GDC). This bias in experience level may also have impacted therapists’ views of their protocol treatments in the current study.

Various findings from this study may have direct implications for training therapists in outcome trials and in clinical settings who are trying to implement protocol treatments. First, it was notable that supervision in the study was perceived as a more important influence on implementing the treatments than the treatment manuals themselves. This underscores the widely mentioned notion that a treatment manual per se may not be enough to adequately prepare therapists. Second, the taping of sessions was perceived by therapists as more influential than adherence scales; this is intriguing in suggesting that simply being observed, rather than actual ratings, may promote compliance with a protocol treatment. The former is less expensive and easier to implement in many settings. Third, therapists reported that it took them an average of over 8 months as well as a high degree of effort (59%) to implement the treatment. However, there was wide disparity on these items according to orientation:

For example, IDCs reported that it took them under 2 months to feel comfortable implementing their treatment, whereas SE therapists needed almost 16 months. When planning the implementation of a treatment, it is thus important to plan for a potentially lengthy training period. Considering that the therapists on this project were carefully selected for previous experience with the treatments and for the high quality of their work, it may be that even more time is needed to achieve adequate levels of implementation among a wider range of clinicians.

Finally, it is worth noting that therapists' primary motivation for wanting to implement the treatments was an intrinsic desire to learn. This appeared far more important than extrinsic factors such as the pay, the threat of job loss, or the use of the treatment by other clinicians. It thus may be important, when engaging therapists to use protocol treatments, to focus heavily on inspiring their interest and captivating their imagination toward the sense of possibility in a new treatment model.

A variety of questions are suggested for future research. How much supervision and training are actually needed to prepare therapists to implement a treatment? Despite the wide array of manuals available, this question has rarely been addressed. The intense, multiyear effort to train therapists on this project is clearly outside the bounds of most real-world settings, yet the minimal amount needed is not yet known. Also, what is the natural evolution of protocol treatments over time? Once therapists learn a treatment to criterion, how do they take it and make use of it in clinical practice when "no one is watching"? A long-term study of this question might help to refine treatments and give a realistic portrayal of the degree to which protocol treatments remain pure versus become hybrids over time. In the current era, the focus is on instilling differentiated protocol treatments, whereas in previous eras the focus was on clinicians' ultimate similarity to each other over time regardless of orientation (e.g., Fiedler, 1951). As is often said, the truth may lie somewhere in the middle of these two extremes, though to a degree that we do not yet know.

Several methodological limitations should be noted when interpreting results of this study. The PIQ was added to the NCCTS after its original design, which means that adequate power to compare the four treatment orientations on this scale

may not have been present. The measure was obtained only at one point in time, and it is unclear how therapists' responses might have changed over time. Also, it was timed to occur after therapist certification at the end of the pilot phase; this limited the sample solely to those who successfully mastered the treatment (thus likely restricting the range of responses). Psychometric characteristics of the PIQ also have not been addressed. Although the sample size and range of orientations were greater than any previous study on this topic, future studies specifically designed from the beginning to evaluate therapists' views may improve on the current study. Also, as noted earlier, therapists represented the very top range of quality, owing to the intensive selection and certification procedures on the NCCTS and to their having applied to be part of this project; results for other clinicians may vary substantially. Similarly, the NCCTS was limited to cocaine-dependent outpatients; results for implementation of treatments with other patient populations also may differ. The study also did not address the relationship between therapist views and patient outcomes or between therapist and patient satisfaction. (The latter is addressed in an earlier article, using a different measure than the PIQ; Siqueland et al., 2001.) Thus, the current report addresses only therapists' subjective views.

In sum, this study appears to provide an early-stage exploration into the inner world of clinicians that goes beyond previous literature in this area. Yet much more research is needed to identify a clear and consistent pattern of results that might help inform future treatment implementation.

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